The Department of Mental Health

Annual Report

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Commonwealth of Massachusetts

Argeo Paul Cellucci, Governor

Executive Office of Health and Human Services

William O'Leary, Secretary

Department of Mental Health

Marylou Sudders, Commissioner

DMH Expands Continuing Care Role

By Marylou Sudders, Commissioner

Severe mental illness, the type treated in the Department of Mental Health's expanded continuing care programs, defines a group of disorders that causes disturbances in thinking, feeling and relating, resulting in substantially diminished capacity for coping with the ordinary demands of life. There are dozens of types; common severe mental illnesses include: schizophrenia, depression, and manic depression. While not enough is yet known to prevent or cure serious mental illnesses, they are treatable.

These illnesses affect individuals of all ages — children, adolescents, adults, the elderly — regardless of race, gender, income, religion, and education. One in every five Americans will experience an episode of mental illness in their lifetime.

Approximately 5 million people, or 2.8% of the adult population, experience severe mental disorders yearly and 9% of children and adolescents between the ages of 9 and 17 are seriously emotionally disturbed.

In Massachusetts, these statistics translate to:

- 600,000 adults with diagnosable mental illness;
- 200,000 adults with serious mental illness;
- 128,000 children and adolescents with serious emotional disturbance.

At any given time, there are: 1,140 adults and kids in DMH inpatient settings; 5,929 in DMH residential programs; 7,000 people with mental illness in DMH-funded clubhouse programs; 9,000 individuals who are DMH case managed; and 18,000 receiving a range of community support services.

Current research shows that severe mental illnesses are biological diseases that interfere with normal brain function. Genetic factors, family history, substance abuse and severe traumatic life crises may create a predisposition. Treatment, which generally combines medications with psychotherapy and supportive services, can and does alleviate symptoms. According to a 1993 National Institute of Mental Health study, the treatment efficacy rates for certain illnesses are:

Disease	% of Patients Improved
Cardiovascular disorders	41%
Schizophrenia	60%
Bipolar disorders	80%

So although severe mental disorders are long in duration, they can be effectively managed and individuals can recover.

One of the ways to treat mental illness is through managed care. It is a concept that is shaping today's health care world and it will continue to do so into the next century. Public mental health authorities have been managing care for years. In and of itself, managed care is not so bad. Yet the mere term generates concern.

The Division of Medical Assistance (DMA) has been providing all acute mental health services, including inpatient and emergency programs, for the past year. It has done so through a managed care company. At the same time, DMH has maintained its responsibility for continuing care in both community and inpatient settings.

Hindsight has taught us that this past year was not a continuation of the status quo. It was the first year for the Massachusetts Behavioral Health Partnership (MBHP), a new managed care company that provided all acute mental health services for DMA. It was a start up operation, with all of the usual attendant difficulties, including new players, overly ambitious goals, unrealistic timelines, new relationships, and different claims procedures.

But, there were benefits for DMH clients. During the past fiscal year (FY'97), the Legislature approved the Department's use of $9 million in funds generated from savings from the DMH/DMA initiative. This partnership allowed the Department to use funds formerly spent on acute inpatient programs to ex-

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pand continuing care and create movement from more to less expensive settings within the system. This ensured that services were clinically appropriate and cost effective.

The reinvestment provided: expanded residential services ($3.4M) for the placement of 70 individuals from state hospitals; development of specialized community programs, such as services for individuals with dual diagnosis, and improved residential supports and respite for 55 other clients; case management ($192,000); day and clinical support services ($2.5M); assessment and extended inpatient services ($268,000); and more than $1.6 million in children's services, including after-school, clinical, residential and respite services. This addressed about 25% of our estimated unmet need.

These funds were allocated in a manner that addressed the historical inequitable resource distribution in the Northeast, Southeastern and Western Mass. Areas. For example, $4.3 million of the $9 million funded expansion of services in the Northeast. The Department has narrowed the disparity of per capita spending between the Areas by more than $400 per person. DMH is committed to achieving the goal of funding equity.

I am committed to improving this relationship with DMA and the Massachusetts Behavioral Health Partnership (MBHP) because of the consequences if it falters. It is my strong belief that we must have a unified system of mental health and substance abuse services, however. The challenge is to bring them together in a responsible way.

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Hopefully, we will continue to move toward a coherent public policy concerning dual diagnosis that matches the needs of individuals. The co-occurrence of addictive and mental disorders is staggering. A coordinated approach is the only way to deal with them.

There is $500,000 in the FY'98 DMH budget to develop additional dual diagnosis programs in conjunction with the Department of Public Health. We also need to retool our state hospitals to meet the needs of individuals with Axis II problems of substance abuse.

The advent of managed care has forced public and private mental health agencies to become more disciplined in their service delivery. There is an emphasis on providing high quality services in an efficient manner. It also offers an opportunity for the state mental health authority to reexamine who it serves and how they are served. Individuals receiving services today are significantly different from those making up our client base less than 20 years ago.

Under managed care, we must ensure that there is a barrier-free, accessible system in place for mentally ill people and that there is a safety net for our most vulnerable citizens.

Whether discussing managed care or waiting lists, the continuing worrisome theme involves access into the mental health system — access in the least restrictive and non-intrusive setting — for treatment that is most effective when it is noncoercive and voluntary. More extensive use of community services is the antidote for unnecessary hospitalization and involuntary commitment of people with mental illness. This goes directly to the issue of empowering indi-

DMH Mission Statement

The mission of the Department of Mental Health is to improve the quality of life for adults with serious and persistent mental illness and children with serious mental illness or severe emotional disturbance. This is accomplished by ensuring access to an integrated network of effective and efficient services that promotes consumer rights, responsibilities, rehabilitation, and recovery.

viduals with mental illness.

One of the reasons state mental health authorities exist is because of long-standing, disparate insurance coverage for medical and mental illnesses. Commercial insurance has significantly limited coverage over the years through caps, and the use of large co-pays and lifetime annual limits for the treatment of mental illnesses that have not existed for medical illnesses. By not providing equitable insurance, individuals look to the public sector for their care and treatment.

Mental health parity provides an opportunity to right a historical wrong. We are moving toward it in Massachusetts. A redrafted bill, Senate No. 1877, has been favorably reported out of the joint Committee on Insurance. It is a compilation of the salient points in five separate bills and addresses the issues originally presented by 15 constituent groups.

This bill is important to all of us. It is time for insurers to treat mental illness as it does any other medical illness. It is no longer okay to allow capricious and discriminatory caps on insurance coverage for mental illness.

More than 40 legislators support the bill. The legislation will align the Commonwealth with 15 states, including all of the other New England states, which have approved mental health parity. Twenty seven other states, including Massachusetts, are debating the issue.

A Coopers & Lybrand actuarial analysis of mental health parity in this state shows the total impact equal to 1.9% increase of current employer claims or about $2.72 per member per month. So, this is not a money issue; it is a fairness issue.

Other legislative bills filed on Beacon Hill in this two-year session have provided a paradox ... some have promoted and some have rolled back basic protections of human rights. Yet adults, children and adolescents with mental illness share the same basic human needs and desires as you and I. They should then share the same rights and responsibilities as every other citizen. For many of us, this is a given, but not for all.

The legislature's joint Committee on Human Services and Elderly Affairs has favorably reported out Senate bill No. 614 and House bill No. 2105, legislation outlining five fundamental rights for people with mental illness. This legislation ensures that people with mental illness have the right to be visited by families and friends; the right to access to legal advocates; the right to make telephone calls; the right to send and receive mail; and the right to privacy while dressing, bathing and using bathroom facilities — regardless of the inpatient setting.

It is important because the public mental health system continues to change, with private and general hospitals playing an increasingly important role in the provision of acute inpatient services formerly provided by DMH. Therefore, we must ensure that basic human rights protections that apply to DMH facilities also apply to private providers.

The bills make these rights applicable throughout the mental health system, ensuring that all mentally ill people — regardless of where they receive inpatient psychiatric services — are treated with dignity and respect. These rights do not cost a cent; they pay important dividends, however.

Worrisome bills have included the legislature's interest in reforming special education. This needs to be watched carefully because it is important to ensure that the kids Chapter 766

was initially intended to serve, including those with mental illness, continue to be served.

The Department of Mental Health, unlike other human service agencies, has dual responsibilities — patient care, as well as public safety. We take our public safety obligations seriously. If we did not, we might see erosion of certain protections that have been offered to individuals. With the recent U. S. Supreme Court decision regarding sex offenders and an expansion of the definition of "mental abnormality," there may be renewed efforts to use civil commitment processes and state hospitals for these folks.

The Department's proposed regulations, which are close to promulgation, take up the matter of human rights in this changing health care world. Among other things, they increase DMH's oversight of the complaint process at private psychiatric hospitals. The Department has not been involved in a substantial way beyond determining whether such hospitals have a process in place during a licensing review.

In expanding our continuing care system, DMH is finding ways to broaden community support services. They are critical to an adult's rehabilitation and for children with serious emotional disturbance to be able to return to school, families and their community activities. Individuals benefit from services that help them build self-confidence and learn or relearn social, vocational, and daily living skills that you and I take for granted. For anyone living with a mental illness, a stable, meaningful life is a goal. For example, nearly $16.1 million of our budget goes to psychosocial rehabilitation programs, which serve 7,000 members each year.

During FY'97, we moved forward to meet our goal -- to improve the quality of life for adults with serious and persistent mental illness and for children with serious emotional disorders -- by ensuring access to an integrated and accredited network of responsive, high quality, cost effective services that promote client rights, continuity, rehabilitation and recovery. In so doing, a few things stand out:

- For the first time in the Department's history, all public mental health facilities are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and certified by the Health Care Financing Administration (HCFA). We now must ensure that they remain so;
- We have improved our relationship with sister human services agencies. The Department has begun productive discussions with the Department of Correction concerning mental health treatment in prisons;
- We have taken proactive steps to address historic inequitable distribution of resources across our Areas. We will continue to do so in this fiscal year;
- We have cleaned up a back log of investigations into complaints filed by DMH clients; and
- We have improved the Department's relationships with legislators.

There should be no doubt that people with mental illness have the right to self-determination, to understand their symptoms and disabilities, to select the direction and means of their rehabilitation, their recovery, their lives. Our task is to ensure that it happens.

FY '98 Goals and Objectives

- Direct the Department in a manner that instills the public's confidence.
- Manage the Department's resources to ensure positive clinical outcomes and cost-effectiveness.
- Reframe the Department's regulatory authority in the new health care environment.
- Promote consumer rights, responsibilities, and recovery opportunities.

DMH Increases Services in FY'97

The Department of Mental Health is providing responsive, high quality, cost effective services to people with mental illness. In this ongoing process, the Department is expanding community-based programs while meeting continuing care needs of individuals in public psychiatric facilities.

The critical components of a strong public mental health system have not changed despite continued changes in the health care world. These components include: flexible community-based programs, cost efficient state hospitals and community mental health centers, and high quality continuing care and acute inpatient and diversionary services. These services must be accessible to those in need. We must not fall into the trap of reducing cost while compromising quality. And we must create movement within the system to ensure services we provide and purchase are clinically appropriate.

After a budget reduction of $26.7 million in FY'91, DMH has experienced moderate budget growth since FY'92. In recent years, spending increases for the mentally ill have been very modest — growth of 1.8% in FY'95, 2% in FY'96, and only 1.2% in FY'97. While there have been minimal increases in resources, the Department has made optimum use of these dollars to address unmet need.

Budget expenditures in FY'97 looked like this:

- $213.8M on state-operated services;
- $338.5M on state-contracted services;
- $165M on inpatient services; and
- $331.8M on community services.

In FY'97, the Department strengthened rehabilitation services and developed programs for people with mental illness and a co-occurring diagnosis of substance abuse. We have a long way to go in these areas in FY'98 and beyond, but our start has produced some encouraging results.

Here is where we stand:

Inpatient Hospitalization

Acute Care: Inpatient & Emergency Services

All acute care is provided in a network of general hospitals with psychiatric units and private psychiatric hospitals across the state. These hospitals are under contract to the Massachusetts Behavioral Health Partnership, a proprietary managed care organization administered by Virginia-based FHC Options Inc. The partnership is in turn responsible to the Division of Medical Assistance/Medicaid. DMH purchases acute inpatient hospitalization and emergency services through an interagency service

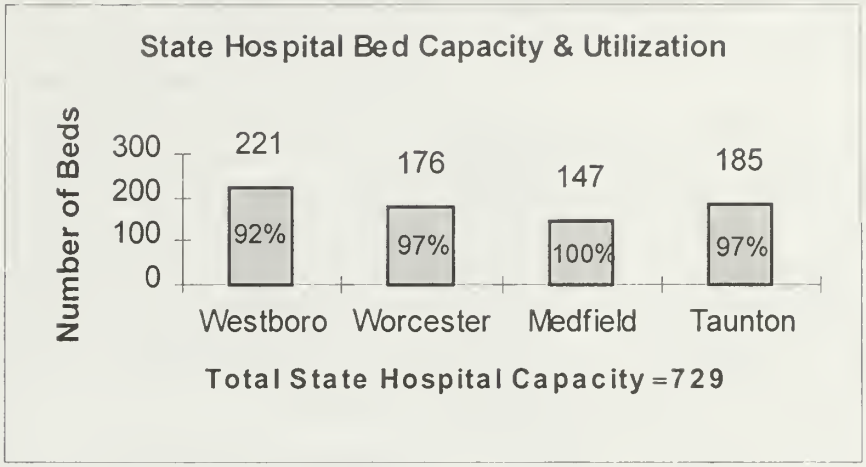
FY '98 Priorities

- Initiate MHIS Project
- Commence statewide planning on dual diagnosis treatment
- Promulgate and implement new regulations
- Finalize Individual Service Planning (ISP)
- Clarify case management responsibilites
- Improve health care access for clients
- Develop public awareness campaign on stigma
- Improve internal communication flow
- Increase efforts to recruit and retain culturally diverse workforce
- Enhance sister agency collaboration
- Implement new program initiatives
- Continue DMA/DMH managed care initiative

agreement with DMA and holds Medicaid responsible for this care. The DMH/DMA initiative supplanted DMH acute care replacement beds and designated emergency treatment programs on July 1, 1996.

This purchasing initiative, covering non-Medicaid, DMH eligible priority clients, strengthens the continuing care system through expansion of services. In FY'97, the Department used $9M formerly spent on acute care to develop or improve rehabilitation that helped adults and children to remain in the community. The Department distributed $7.8M to its Areas for program development; the remaining $1.2M was used on one-time expenditures to prevent program reductions.

Residential services were increased by more than $3.4M, allowing for the placement of 70 adults from state hospitals; the development of specialized community programs, such as services for individuals with dual diagnosis; and improved residential supports and respite for 55 other clients. Day and clinical support services were increased by nearly $2.5M, allowing clients to live in the community through expanded mental health programs, medical treatment, medication monitoring, and support, educational and employment opportunities. Case management was increased by $192,000 to extend the Department's ability to effectively manage the care of clients discharged from state facilities. Assessment and extended inpatient services were increased by $268,000 to provide specialized assessments to determine appropriate levels of care. Residential and respite services for children were increased by $600,000 to expand respite capacity and residential treatment for 120 seriously emotionally disturbed children and adolescents. After-school and clinical support day services for children were increased by $1M, allowing 350 seriously emotionally disturbed youngsters to remain with their families through in-home treatment.



State Hospitals & State-Operated Community Mental Health Centers

DMH continues to directly operate 13 facilities statewide, which include four continuing care psychiatric hospitals — Taunton, Medfield, Westboro and Worcester state hospitals — and nine community mental health centers — Quincy, Corrigan (Fall River), Pocasset (Cape Cod), Brockton, Solomon (Lowell), Lindemann (Boston), Bay Cove/Shattuck (Boston), Massachusetts Mental (Boston) and Solomon Carter Fuller (Boston). The Department's continuing care state hospitals and community mental health centers have a total of 986 beds, including two adolescent units for children 13 through 18 operated by the University of Massachusetts at Westboro State Hospital, and one adolescent unit for the same age group operated by Charles River Health Management at Taunton State Hospital.

Three of the five community mental health centers (CMHCs) outside Metro Boston have 16-bed acute care inpatient units (Quincy, Corrigan in Fall River, and Pocasset on Cape Cod). The Brockton Multi-Service Center and the Harry C. Solomon Mental Health Center in Lowell do not have inpatient units. In the Metro Boston Area, three of the four CMHCs — Lindemann, Solomon Carter Fuller, and Bay Cove/Shattuck — provide both acute and continuing inpatient care. The Massachusetts Mental Health Center

has 12 beds, with statewide access, for research and evaluation.

DMH contracts with Olympus Hospital in Springfield to provide continuing inpatient care for 30 adults in Western Massachusetts while the same type of care is offered in 180 beds in the Hathorne units at Tewksbury Hospital in the Northeast Area. For children ages 5 through 13, DMH contracts for a 16-bed continuing care unit at Westwood Lodge.

JCAHO Accreditation HCFA Certification

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a national group, surveys facilities to ensure that quality services are provided and evaluated in relation to national standards. The Health Care Financing Administration (HCFA), an arm of the federal government, certifies inpatient beds to qualify for federal financial reimbursements under Medicaid and Medicare.

For the first time in decades, all DMH operated public psychiatric facilities now meet JCAHO standards and all have received HCFA certification. The Solomon Carter Fuller and the Erich Lindemann Mental Health Centers in Boston were the final DMH facilities to receive JCAHO accreditation and HCFA certification. In FY'91, only 22 percent of DMH inpatient beds were certified.

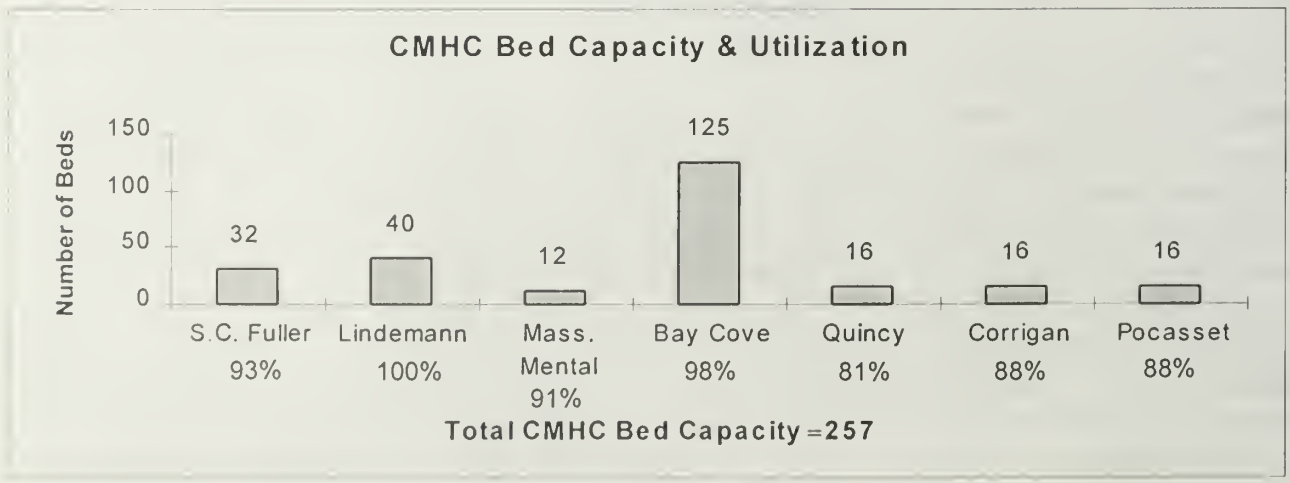
Community Support

Child/Adolescent Initiatives

A network of community-based services, which provides both early intervention and intensive programs to reduce the need for out-of-home placements, enables children to make treatment gains and to function in community settings. The following initiatives have been undertaken: development of after-school programs for latency-age children; expansion of school-based contracts to include violence prevention programs; expansion of home-based intervention contracts; broadening of existing interagency teams; and earmarking of resources to purchase "wraparound" services — that is, services tailored to meet a child and family's needs.

The Collaborative Assessment Program (CAP), a pilot with the Department of Social Services (DSS) in the Southeastern Area, operationalized an interagency restructuring of services for children and adolescents to create a unified case management system, provide prompt assessments of the needs of children and their families, eliminate duplication of services and define each agency's role and funding responsibilities. Of the assessments on the first 69 different families, only 16 youths, or 23%, of those referred with an initial issue of "in need of residential" placement were recommended for such placement. The pilot will be expanded statewide in FY'98. When fully implemented, the CAP is expected to serve 300 to 350 families annually.

Massachusetts is working under a four-year grant of $2.8M from the Annie E. Casey Foundation to provide early in-



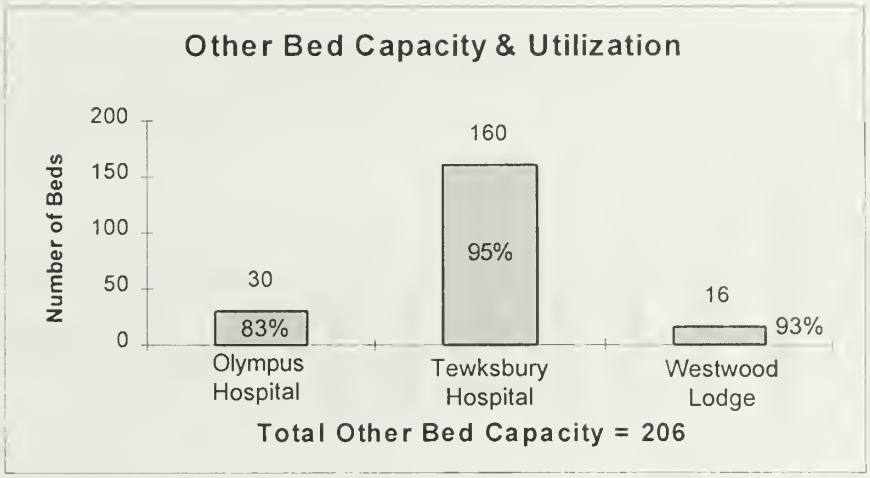
tervention and prevention services and supports for 7,000 urban children "at risk" of severe mental illness and serious emotional disturbance and their families. This initiative involves a partnership of the state, the City of Boston, and a neighborhood governing board from the Boston neighborhoods of Lower Roxbury, Mission Hill and Highland Park-Washington Park. DMH continues to be the lead state agency. During FY'97, a total of 28 children placed outside their homes returned to their families; 259 "at risk" children were diverted from out-of-home placements; a satisfaction score of 89% from a survey of 185 families receiving services was recorded; decreases in depression, post traumatic stress disorder, abuse, arrests and an increase in overall child and family functioning when using the Child Adolescent Functional Assessment Scale and the Children's Behavioral Checklist were experienced.

Residential Programs for Children

Intensive Residential

The Department offers three different types of residential services for children and adolescents depending on their acuity.

DMH contracts for two secure Clinically Intensive Residential Treatment programs (CIRTs) for children (ages 5 through 12) with 21 beds at: The Brighton Center for Children and Families (11 beds) operated by Charles River Health Management in Boston; and Three Rivers (10 beds) operated by Northampton Center for Children in Holyoke.



Intensive Residential Treatment Programs (IRTPs) for adolescents (ages 13 through 18) include 72 beds at: Centerpoint (12 beds) operated by Justice Resource Institute in Tewksbury; Chauncy Hall (16 beds) operated by Northeastern Family Institute at Chauncy Hall/Westboro State Hospital; the University of Massachusetts Intensive Residential Treatment Program (12 beds) at Worcester State Hospital; Charles River Intensive Residential Treatment Program (16 beds) operated by Charles River Health Management at Taunton State Hospital; and Solomon Carter Fuller Mental Health Center (16 beds) operated by Pembroke Hospital/Westwood Lodge. In addition, the Department contracted for 309 community residential beds for children and adolescents in FY'97 and purchased additional slots on an as-needed basis within the limits of available funding.

Adolescent Step-down Programs

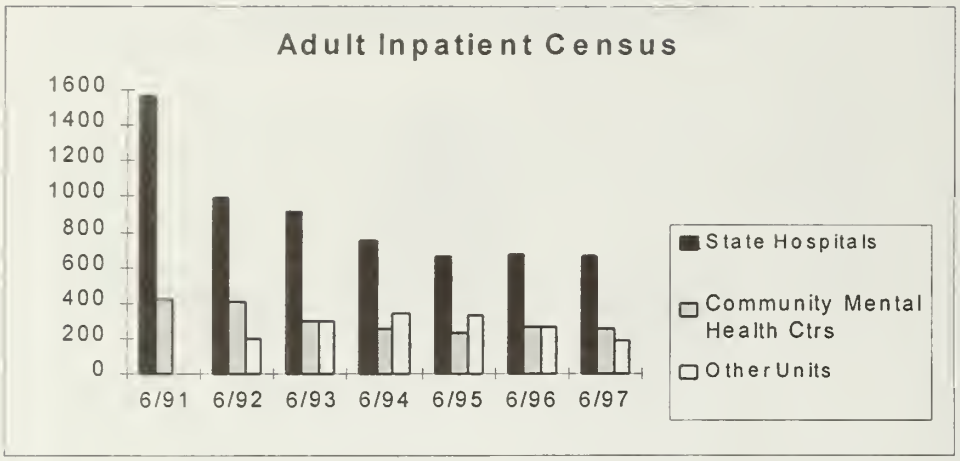
Pathways Residential II (6 beds), an IRTP graduate program operated by Health & Education Services at Westboro State Hospital, and Swansea Wood School (3 beds), a staff secure residential program for ED/MR adolescents operated by Justice Resource Institute in Swansea, are two DMH step-down programs for adolescents.

Residential Services

Adult Community Services

Since 1992, the Department has invested $70M of $74M saved since restructuring and consolidating facilities. The funds helped DMH to expand community-based services. More than 65% of the Department of Mental Health's $537.7M FY'98 budget is committed to community-based care, up from 49% in FY'91.

DMH developed 1,518 new residential beds in the community between FY'91 and FY'96. The DMH residential



capacity for adults now stands at 5,201 while the Department has access to 288 additional beds through an agreement with MHFA. In FY'97, the Department brought 122 new residential units on line, including 72 for homeless people with mental illness.

In addition, the Department assisted clients in locating apartments in the open rental market. More than 800 individuals now live independently in the community. Housing opportunities have been expanded from a system serving 2,100 people with mental illness in 1988 to a system that serves more than 5,700 people with mental illness today. The Department is slated to add another 203 units in FY'98. DMH has 239 residential contracts and expects to spend $151.8M on residential services in FY '98.

Siting residential programs continues to be a struggle. DMH faces significant community resistance across the Commonwealth.

Housing Services

Originally a pilot program at six locations, DMH now funds service coordinators on site at 15 local housing authority developments for the elderly and disabled. This initiative is centered on service coordination from field managers who are based on site and provide daily consultation and referrals. In an evaluation conducted by the McCormack Institute at UMass Boston, this program was rated very favorably. Also, affiliation agreements have been established with many local housing authorities to facilitate the accessibility of DMH services to the housing community, including public housing tenants.

The same legislation is funding innovative rental assistance called the Alternative Housing Voucher program. It provides up to 800 rental subsidies to younger people with disabilities who are on waiting lists for state-aided public housing. Of these 800 vouchers, 15% may be allocated to younger people with disabilities currently living in state-aided developments for the elderly and disabled.

Employment

Employment services provided by DMH have evolved to reflect the growing emphasis on providing community-based, integrated services to clients. The Department provides a mix of services ranging from placements in enclaves and work crews to supports in finding and maintaining competitive, independent employment. In addition, clubhouses, which offer psychosocial rehabilitative support services, provide an important link to employment available to DMH clients.

In FY'97, DMH issued a request for proposals for a new initiative, Services for Education and Employment (SEE), which emphasizes consumer choice in selecting, obtaining and maintaining jobs as well as educational placements. The program encourages career planning, typically in pre-placement counseling sessions, and offers flexible and individualized supports that enable individuals to maintain employment and educational placements. A critical piece of the SEE program is the network of linkage developed between SEE providers and mainstream providers of employment, education and job training programs. Twenty-nine SEE contracts totaling $5.1 million were awarded statewide.

Linkage between mainstream providers of employment/ job training, and education ser-

vices are valued because clients will be served in an integrated setting, alleviating the isolation often experienced by the mentally ill. Accessing mainstream resources also represents a more effective use of limited state funding. Whenever possible, DMH dollars are used to provide support services to individuals utilizing resources paid for by generic employment and educational programs available to all residents of Massachusetts.

Two successful examples of this model currently operate statewide and serve the homeless mentally ill. They involve partnerships with the Division of Employment and Training (DET) for career planning, job development, and placement services for DMH consumers.

Employment Connections, which began serving Metro Boston Area clients in FY'96, has resulted in 209 placements in full-time, part-time, temporary, and on-call jobs. The average wage is $7.63 an hour. This program is funded through state homeless dollars, and serves individuals who have mental illness and are homeless and/or at-risk of homelessness. Department of Mental Health funding is used to purchase designated DET staff time allocated exclusively to DMH clients. Support services are provided by natural service site personnel. The budget for this program in FY'98 is $160,125. Individualized DET services will be provided to 200 clients; half of whom will be placed in full or part-time jobs during the fiscal year.

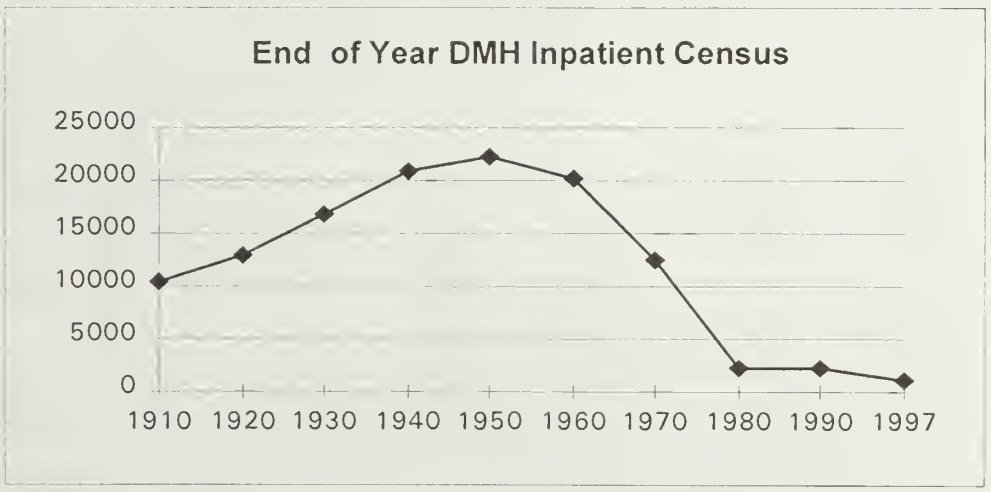
Employment Connections II began serving clients early in FY'97. This program, an expansion of the Boston pilot, has resulted in 114 placements in full-time, part-time, temporary and on-call jobs. The average hourly wage per placement is $6.78. This three-year program is funded through a $2.1M grant from HUD's Stuart B. McKinney Homeless Assistance Fund. The FY'98 budget for DMH services provided through this program is $374,250. Located in seven sites across the state — Lowell, Lynn, Framingham, Hyannis, Springfield, Quincy, and Worcester — this program serves a more restricted pool of homeless and mentally ill individuals. Therefore, many enrolled clients require an initial period of stabilization services to ready them for the job search process. Employment Connections II's program design accommodates this restriction by funding DMH provider staff that links program participants to appropriate services. Like Employment Connections, this program has designated DET staff to work exclusively with DMH clients providing individualized employment services in an integrated setting.

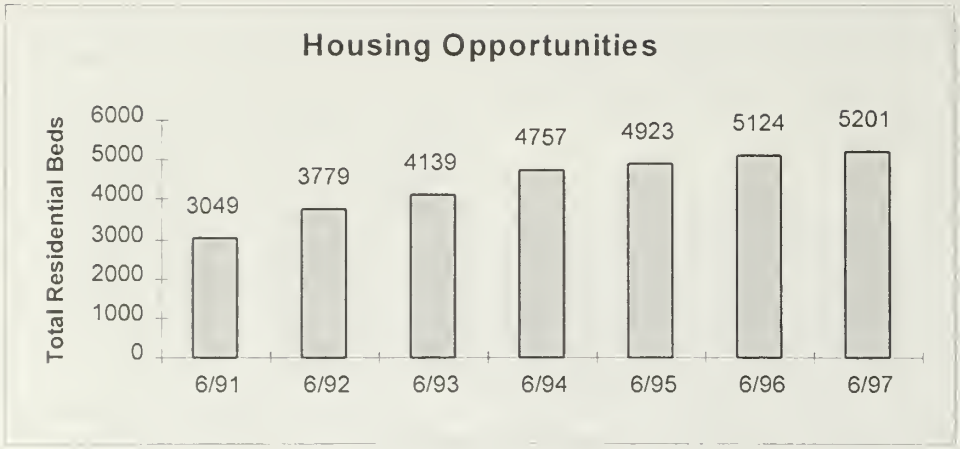
Clubhouses

Funding for consumer clubhouses — community support programs offering housing, vocational training, temporary, part-time job placements, meals and social contacts — was increased from $11.3M in FY '91 to $16.1M by the end of FY '97, an increase of $4.8M.

Client Initiatives

For the past six years, DMH has set aside grants for clients to develop and operate their own businesses. Central Office earmarked $94,0000 for 11 projects, while the Western Mass. Area supported 14 projects with $60,000 in funding, the Metro Suburban Area allocated $76,000 for three projects, and the Southeastern Area supported five initiatives with $13,000.





The agency also believes in a strong consumer voice and diversity of opinion. As an example, the Department funds M-Power with a $127,369 contract and has done so since 1990.

Case Management

DMH has expanded case management, supervisory and support staff for adults and children. By the end of FY '96, case management, supervisory and support staff totaled 507; by the end of FY'97, this had been increased to 523. By comparison, there were 327 case managers in FY'91. A total of 11,156 individuals — 9,746 adults and 1,410 children and adolescents — were assigned case managers during FY'97, including 2,166 new assignments. A total of $15.9M was expended for direct case management in FY'97.

Special Populations

Homeless Mentally Ill

DMH operates a special initiative for people with mental illness who are homeless with $14.1M annually in state appropriated funds for statewide service projects. Through this initiative alone, more than 700 people with mental illness who are homeless were served through the end of FY '97. An additional 200 mentally ill people who are homeless were helped through other DMH efforts.

For FY'98, DMH received $2 million from the legislature for expansion of the homeless mentally ill initiative. The legislature also designated an additional $1 million from DMH/ Division of Medical Assistance (Medicaid) retained revenue, to be generated from maximizing federal financial participation for emergency screening services and inpatient acute care, for the homeless mentally ill. The total: $3 million in expansion funding. The $3M will allow the Department to leverage $11.1M in additional federal and state dollars and to create up to 170 residential slots for homeless mentally ill individuals. Appropriated funds for this initiative are annualized in the DMH budget.

DMH homeless initiative dollars are used primarily to provide clinical and residential services and to leverage federal resources to fund development or to access housing units (bricks and mortar). DMH dollars also are used to fund outreach programs to homeless mentally ill individuals in transitional housing (shelters), on the streets, and in rural areas.

The DMH discharge policy is aimed at preventing homelessness. The policy states that the Department will not discharge a client from a state-run facility to a shelter or to the streets and that every effort will be made to help the client find adequate, permanent housing.

DMH has instituted an enhanced discharge protocol for its Metro Boston Area, the area with the highest number of homeless people in the state (about 1,200 of an estimated 2,000 statewide). Boston operates a Homeless Services Unit which, among other things, monitors the discharge process and identifies supportive housing options for clients. All individuals discharged from state-operated facilities participate in individual service planning. This includes a hospital treatment team and case manager who determine residential and support needs as well as eligibility for entitlements.

Forensic Mental Health Court Clinics

The forensic mental health system performed 8,005 adult and 2,486 child/adolescent court clinic evaluations in FY'97

and provided mental health services to 11 county correctional facilities and to women prisoners at MCI Framingham. This represents about 40% of the total number of evaluations performed. Most inpatient evaluations are done in state hospitals. In addition, consultation and evaluation services were provided to the state parole board and mandatory forensic reviews were done at inpatient facilities to help determine privileging and patient discharge.

For seriously mentally ill persons in county correctional facilities, DMH provided the following services: (a) initial assessment and follow-up; (b) crisis intervention; (c) evaluation and transfer functions; (d) psychiatric evaluation and treatment (medication); (e) release planning and liaison to community mental health services. In addition, consultation and training regarding the identification and management of seriously mentally ill persons was provided to correctional and medical staff.

Measuring Performance

Quality Management

The Department has a quality agenda and Quality Councils in all Areas. In FY '94, DMH's quality management training efforts were expanded to include line staff, family members and clients who were working on specific problem identification and problem-solving activities. Quality management performance standards and performance outcome measures are in place for providers. They call for providers to participate on local site Quality Councils, to serve as quality team members, to have a written quality improvement plan, and to document findings from their quality management activities. These activities have led to reductions in restraint and seclusion, improved treatment of the dually diagnosed, reduced hospital readmissions, and a reduction in readmissions of the same patient to multiple hospitals;

In FY'95, quantifiable data concerning licensing, medical records, critical incidents, and the like was used for the first time in the history of the Department in an RFP process to rate provider performance. This would not have been possible without an established management program directed at the Area Office level. These programs did not exist before 1991.

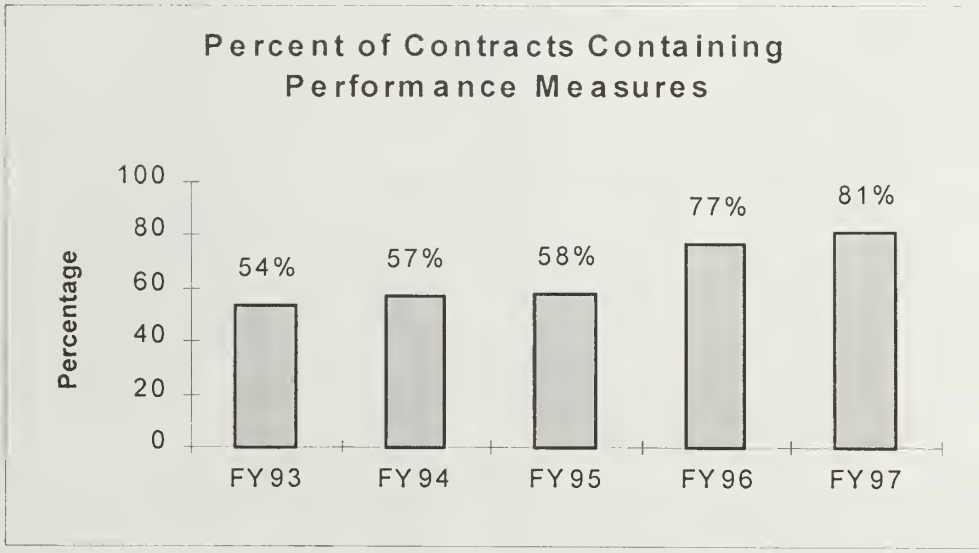
Licensing

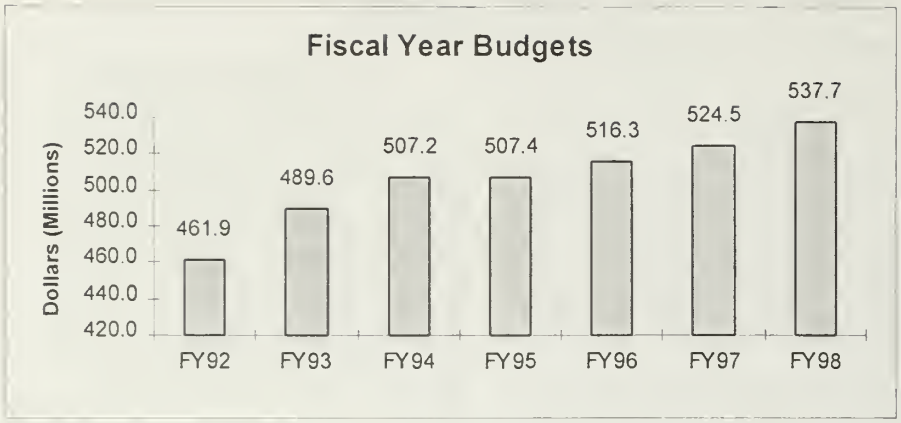
All Areas now meet the Department's licensing mandate with 10 full time equivalent licensers to address DMH's community residential licensing needs. The Department of Mental Health licenses a total of 56 private psychiatric hospitals and psychiatric units in general hospitals.

Research

Centers for Excellence

DMH funds two Research Centers of Excellence overseen by a statewide Research and Advisory Board, chaired by the Deputy Commissioner of Clinical and Professional Services. These centers apply the best minds and talent in Massachusetts to advance treatment and rehabilitation modalities for chronic, persistent and severely psychiatrically ill patients. The two centers are The Center for Psychosocial and Forensic Services Research, affiliated with the University of Massachusetts





Medical School, which concentrates on behavioral and forensic sciences, and The Commonwealth Research Center, affiliated with Harvard Medical School, which focuses on clinical neuroscience and neuropharmacology.

A portion of the Psychiatric Residency and Psychology Internship Training programs at medical schools in Massachusetts is also funded by the Department.

Technology

Mental Health Information System (MHIS)

The Department has been continuing the expansion of the statewide telecommunications network. Currently, all area offices and most of the local service sites are connected to the wide area network. This structure improves internal communication at the Department, but more importantly, it is the communication foundation for the Mental Health Information System.

The need for an integrated Mental Health Information System has been driven by the following questions regarding DMH's accountability for its clients:

- Who is a DMH client?
- What services do DMH clients receive?
- Where do they receive services?
- What is the cost of these services?

The Mental Health Information System will be a client information system that enables the Department to register consumers, record their eligibility and service utilization, handle billing functions related to those services, and will have the capability to maintain clinical and service information with built-in safeguards regarding client confidentiality. The goals include:

- Provide registration/ enrollment, service delivery/ billing and clinical/service management functions;
- Develop and follow a carefully planned implementation and roll-out;
- Implement a long-term solution with the support of a viable vendor;
- Be usable across all six geographic areas;

In FY'94, the Department began a phased-in project to expand and improve upon information concerning clients using DMH services and to reduce the duplication of multiple information systems. The first two phases were scheduled to be the Registration and Enrollment System (RES) and Client Accounting and Billing System (CABS). During their development, the Department found that software products were available commercially which would meet the business needs of RES and CABS, and match the technical requirements at DMH.

A request for responses (RFR) for a MHIS has been completed and vendors evaluated. A contract is expected to be awarded by year's end with implementation slated for 1998.

Did You Know?

1833: Worcester State Hospital, the first public mental health facility in the country, opens;

1879: State Board of Health, Lunacy and Charity created;

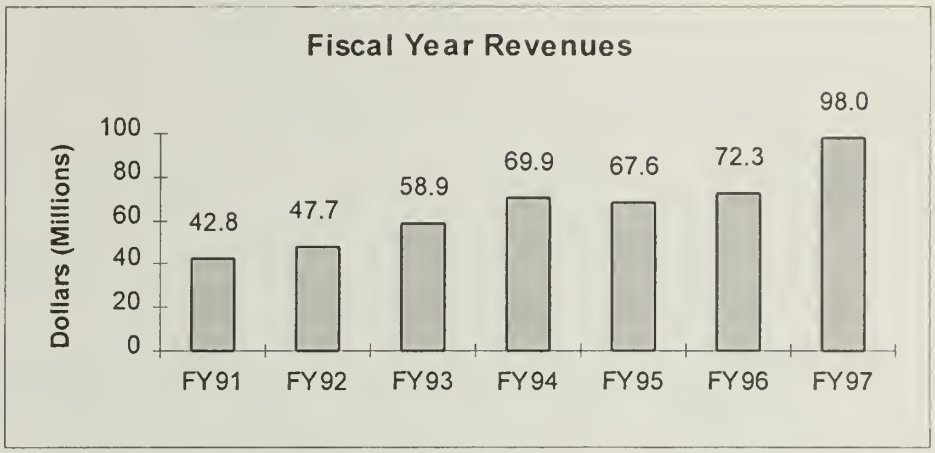
1898: State Board of Insanity created;

1912: Boston Psychopathic Hospital, later known at Massachusetts Mental Health Center, opens; pioneers concept in treatment of mental illness, includes on-site training of psychiatrists

and research;

1916: Massachusetts Commission on Mental Diseases, later known as the Department of Mental Diseases, created;

1938: Department of Mental Diseases reorganized following Special Commission's Report — Department of Mental Health created;



1948: Dr. Erich Lindemann establishes the first community mental health center in the country — the Human Relations Service, Inc., in Wellesley;

1961: Joint Commission on Mental Illness and Health issues findings and recommendations; leads to development of community-based services in Massachusetts;

1963: Massachusetts Mental Health Planning Project created; results in creation of Mental Health Area Boards;

1978: Western Mass. Brewster consent decree initiated; DMH disengaged in 1992;

1984: Executive Order 244 signed — prohibits children/adolescents under 19 from being treated on adult inpatient units;

1985: Governor's Special Message on Mental Health — a long-range plan to dramatically improve and expand the mental health service system; expand case management and emergency services; proposes 2,500 new residential units;

1986: Ch. 599 split DMH/DMR and created new mission for DMH, effective 7/1/88;

1987: $340M Capital Plan approved to upgrade and staff state hospitals and fund 2,500 new housing units;

1991: Governor's Special Commission on Facility Consolidation; report issued in June 1991; recommended that DMH close three state hospitals (Metropolitan 1/92, Danvers 6/92, and Northampton 8/93); Gaebler Children's Center later recommended for closure (9/92);

1992: Commonwealth establishes a first-in-the-nation Medicaid behavioral health contract for mental health and substance abuse with Mental Health Management of America; implemented as a result of a federal waiver;

1993: Center for Mental Health Services publishes new definitions of serious mental illness (adults) and serious emotional disturbance (children) in Federal Register;

1994: Massachusetts awarded a $3M Annie E. Casey Foundation Mental Health Initiative for Urban Children;

1994: Legislature approves transfer of clinical responsibility for the Treatment Center for the Sexually Dangerous at Bridgewater from the Department of Mental Health to the Department of Correction; effective 8/1/95;

1995: DMH collaborates with DSS and DMA on a pilot program in the Southeastern Area to improve coordination of services to seriously emotionally disturbed children and their families with introduction of Collaborative Assessment Program (CAP);

1997: DMH begins revising regulations to provide improved organizational structure, simplify and clarify language, eliminate duplication and better reflect and address issues related to current public mental health system.

DMH Central Office
Operator: (617) 727-5600
Marylou Sudders, Commissioner
(Marianne Callinan, Assistant to the Commissioner/Office Manager)

Marilyn Berner
Chief of Staff

Peter Morin
Director of Internal Affairs

Stephen Cidlevich
Director of Constituent and Legislative Affairs

John Widdison
Public Affairs Director

Jeff McCue
Deputy Commissioner
Management and Budget

Larry Hookey
Assistant Commissioner
Applied Information Technology

Perry Trilling
Assistant Commissioner, Administration/Finance

Michael Coughlin
Assistant Commissioner, Human Resources

Marilyn Carrington
EEO, AA Administrator

Paul Barreira, M.D.
Deputy Commissioner, Clinical/Professional Services

Gary Pastva
Assistant Commissioner, Clinical/Professional Services

Joan Kerzner
Director of Policy Development

Carolyn Schlaepfer
Deputy Commissioner, Program Operations

Joan Mikula
Assistant Commissioner, Child/Adolescent Services

Ellie Sullivan
Assistant Director, Program Operations

Steve Holochuck
Director, Office of Consumer and Ex-Patient Relations

Deborah Scott
Assistant Commissioner, Forensic Services

Jennifer Wilcox
General Cousel

DMH Local Service System

Western Massachusetts
James Duffy
Area Director
413-584-1644
Central/South Berkshire
Franklin/North Quabbin
Hampshire
Holyoke/Chicopee
North Berkshire
Springfield
Westfield

Central Massachusetts
Constance P. Doto
Area Director
508-752-4681
Milford
Southbridge
Gardner
Fitchburg
Worcester

Metro Suburban
Theodore Kirousis
Area Director
508-359-7312
Medfield
Westboro
Quincy
Arlington

Northeast
Mark Fridovich
Area Director
978-851-7312
Beverly
Greater Lowell
Greater Lawrence
Haverhill/Newburyport
Lynn
Wakefield

Southeastern
John P. Sullivan
Area Director
508-580-0800
Brockton
Cape Cod
Fall River
New Bedford
Plymouth
Taunton/Attleboro

Metro Boston
Clifford Robinson
Area Director
617-727-4923
Bay Cove
Cambridge/Somerville
Lindemann
Mass. Mental
Solomon Carter Fuller